2017/2018 School Year

New form needed EACH year!

Molar EXPRESS

North Country HEALTH CONSORTIUM

Molar Express is a portable dental clinic that is equipped to provide services typically found in any general dental practice. Our services include: Exams, Cleanings, Sealants, X-rays, Fillings, Extractions, etc.

We will be offering School-Based Clinics. Students receive dental care without having to miss a day of school!

REGISTRATION FORM

Please keep the top sheet (Privacy Rights & Practices) and return the 2nd page of this form to your school

Is Molar Express for my child?

The Molar Express program is for children who **do not** have a dental care home (regular dentist) **or** who are not able to get dental care because they are on NH Medicaid **or** cannot get to a dentist for other reasons. No insurance? We can help: Fill out the form and one of our team members will reach out to you with options.

Our contact information:

- Go to our website: www.nchcnh.org (click on the truck!)
- Call us at (603) 259-3700
- Email us a request at molarexpress@nchcnh.org
- Address: Molar Express, 262 Cottage Street, Suite 230, Littleton, NH 03561

We look forward to seeing your child's smile soon!

Molar Express

Patient's Rights and Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. If you are a parent or personal representative acting on behalf of an unemancipated minor, "you" and "the patient" in the document below refers to the child. **Please review it carefully**.

Uses of Information and How Information is Disclosed

Information given to The Molar Express and its staff may be used for treatment, including for: 1) identifying treatment goals agreed upon by both patient and staff; 2) setting a plan of treatment for pursuing those goals; and 3) monitoring effectiveness of the treatment plan. An example of each of these would be: the Dentist suggests a treatment plan for the patient and the patient and Dentist (or the Dentist's representative) talk about the treatment plan and agree on the services to be provided.

Information given to The Molar Express and its staff may be used as The Molar Express and/or its agents seek payment for services, including: 1) mailing invoices to a patient at the address given by the patient; 2) submitting patient information to insurance providers, if the patient requests this, such as social security number, date of birth, address, dental diagnosis, insurance policy number, and dates of service; 3) writing, phoning, or e-mailing the other payer(s), if the patient requests this, and identifying the patient, to seek payment for services; and 4) giving patient information such as social security number, date of birth, address, and dates of service to a collections agency if the patient makes no payment arrangements as per the payment agreement.

Information given to The Molar Express and its staff may be used by The Molar Express and/or its agents for dental care operations, in the sense that staff may make and/or track appointment times and will write in patient chart information about dental diagnosis and treatment services provided. Staff may telephone the patient with appointment reminders and other treatment related information. Information may be used and shared for your treatment and care coordination.

Information will be disclosed generally by providing hand delivered materials in sealed envelopes, via United States mail, talking on the phone, or encrypted email service when disclosure is appropriate. However, with a few exceptions (see below), information about a patient will not be disclosed to anyone outside of The Molar Express without the patient's written authorization. The patient may revoke such authorization at any time; revoking authorization requires two actions by the patient: 1) telling or writing such to staff; and 2) ensuring that their request has been received by staff, by for instance asking staff to state understanding that authorization is revoked.

Without the patient's written authorization, information about a patient will not be disclosed to anyone, with the following exceptions: 1) if staff determines that the patient or someone else is at risk of eminent physical harm; 2) if staff determines that a child, (meaning anyone under 18 years old) might have been or possibly is being physically harmed, neglected or endangered; 3) if staff determines that a senior (meaning anyone 60 years old or older) might have been or possibly is being physically harmed, neglected or endangered; 4) if there is a medical emergency; or 5) if ordered by a judge. In such situations, staff will provide information deemed useful to ensure safety or to abide by applicable law and may take steps to ensure safety, including for example calling police or arranging a hospital visit.

Patient's Rights

The Molar Express patient has the right to: 1) request restrictions on certain uses and disclosures of protected health information, although The Molar Express is not required to agree to the request; 2) receive confidential communications of the patient's protected health information; 3) inspect and copy protected health information; 4) request to amend protected health information; 5) receive an accounting of disclosures of protected health information; and 6) receive a copy of this notice upon request.

Responsibilities of The Molar Express

The Molar Express is required by law to: 1) maintain the privacy of protected health information and to provide patients with notice of this responsibility; and 2) follow the terms of this notice whenever transmitting patient information by computer and 3) offer patients a revised copy of this notice if The Molar Express revises this notice in the future.

Complaints

If you believe your privacy rights have not been upheld, you may inform The Molar Express and its staff at 603 259-3700. The best approach for addressing such complaints would be to discuss it with The Molar Express staff. If after doing this you are not satisfied, you may call the HIPAA Hotline at 866-627-7748 or www.cms.hhs.gov/hipaa.

KEEP THIS PAGE FOR YOUR RECORDS

2017/2018 School Year

Molar Express

PATIENT REGISTRATION FORM

Please complete **BOTH SIDES** of this confidential form, **sign the back of this form (2 places) and return** to your child's school. **Please remember children who already have a dental home (regular dentist) are not eligible for the Molar Express.** This program is for children who are not able to get dental care because they are on NH Medicaid or cannot get to a dentist for other reasons. We appreciate your understanding. If you have any questions please call Francine Morgan, The Molar Express Program Manager at 603-259-3700 ext. 232.

CHILD

Child's Name: _____ School: _____

Nickname: _____ Grade_____ Date of Birth _____/_____/_____ Age _____ Sex (M) or (F)

_____

(home address) *(town)* *(state)* *(zip code)*

CONTACT

Parent/Guardian Name(s)_____ Who does child live with? _____

******(Phone contact information is required so the Dental Team may talk with you about your child.)******

Primary Phone # (_____)_____-_____ *(home / cell / work)* Alternate Phone # (_____)_____-_____*(home/ cell / work)*

Email address_____ Preferred contact through: Phone / Email / Text

Please list names of who we can speak to regarding your child's dental needs/appointments:_____

HISTORY

____ My child **does NOT have** a regular dentist. _____ My child was seen by The Molar Express last year.

____ My child **HAS** a regular dentist and does **NOT** need Molar Express.

Please list any information you want us to know about your child's dental needs: _____

_____

Previous Dentist's Name _____

Date child was last seen by Dentist: _____/_____/_____ Reason seen: _____

Date child last had their teeth cleaned: _____/_____/_____ Does your child take fluoride tablets? Yes / No

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INSURANCE

Check the appropriate statement regarding your child's dental insurance:

___ Does NOT have any type of Medicaid or Dental Insurance

___ Has Medicaid Insurance. Their insurance number is: *(typically located at the bottom of their card*)

New Hampshire: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Vermont:** ___ ___ ___ ___ ___ ___ ___

____ Has Dental Insurance through a parent *(attach a copy of both sides of the insurance card)*

Insurance Co. Name: _____ Phone: (_____)_____-_____

Group #:_____ Policy _____

Subscriber's Name: _____ Subscriber's Date Of Birth: ____/____/_____

OVER: PLEASE FILL OUT AND SIGN OTHER SIDE

OFFICE USE ONLY:

_____

_____

CHILD'S MEDICAL HISTORY

Regular Doctor's Name _____ Doctor's Phone # # (_____)_____-_____

Does child have or has child ever had any of the following? Please check those that apply:
* This condition may require antibiotic premedication for certain dental procedures.

[ ] Abnormal Bleeding
[ ] ADD/ADHD
[ ] Allergies/Hay Fever
[ ] Anemia
[ ] Artificial Joints*
[ ] Artificial Heart Valves*
[ ] Asthma
[ ] Blood Disorder
[ ] Blood Transfusion
[ ] Breathing Problems
[ ] Cancer
[ ] Chemotherapy
[ ] Cold Sores/Fever Blisters
[ ] Colitis
[ ] Congenital Heart Disorder*
[ ] Diabetes
[ ] Drug or Alcohol Abuse
[ ] Epilepsy or Seizures
[ ] Fainting or Dizziness
[ ] Heart Murmur*
[ ] Heart Surgery
[ ] Hemophilia
[ ] Hepatitis
[ ] Herpes
[ ] High Blood Pressure
[ ] HIV*/AIDS
[ ] Kidney Problems
[ ] Low Blood Pressure
[ ] Mitral Valve Prolapse*
[ ] Organ Transplant
[ ] Psychiatric Disorder
[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Sinus Problems
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Venereal Disease

If you marked "YES" to any items on the above list, please explain: _____

_____

Please list any other health conditions your child has _____

_____

Is your child allergic to any medications or substances? Yes / No If yes, please check box below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Foods [ ] Other _____

_____

Please list any medications your child is taking:_____

*Does your child require antibiotics before dental work? Yes / No

Please list all siblings:

1. Name: _____ Age: _____ School: _____
2. Name: _____ Age: _____ School: _____
3. Name: _____ Age: _____ School: _____
4. Name: _____ Age: _____ School: _____

Do you have any other information you want us to know about your child?_____

Permission & Privacy Practices

*** * *** PLEASE READ THIS SECTION AND SIGN **BOTH** LINES BELOW *** * ***

I give permission for my child to be considered for the Molar Express program and, if accepted, to receive dental care. Dental care includes cleaning teeth (polishing), topical fluoride treatments, and bite wing x-rays. Sealants, regular cavity fillings, and temporary fillings will be provided, only as necessary and in collaboration with the dentist. I understand that the dentist will provide a treatment plan for my child before extractions (removing teeth). Extractions will require an additional signed permission form. If you have any questions, please feel free to call us at (603) 259-3700.

SIGN HERE_____ _____

(Signature of Parent/Guardian giving permission to treat your child) Date

I acknowledge that I received a copy of The Molar Express Notice of Privacy Practices *(attached sheet)*.

AND

SIGN HERE_____ _____

(Signature of Parent/Guardian for receipt of Privacy Practices) Date

Please return this confidential form to your child's school.